Date/Time	Inmate's Name: Wright Richard 187748 D.O.B. 8/15/67
5.5.05	WT 178 BP 120/84 PEX R20 T 98.8 O2 84% S/" Constant dry cough - blurred vision - need profile for Master lock - rash on face - headached"

(T) HA
Blurred vision
S/P—
Cough

(O) AXOX3
HEENT & Except Tender over - (R) frontal Sinus
PERRLA EOMI
Lungs CTA
CV-NSR
Abd - Benign
M/S. NL.

(A) Chr. Allergic Rhinitis.
facial (mild) folliculitis

(P) S/P.
ETOH +
(E) Reg. Exercise
MH. Counseling

R.

PHS

PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: D.O.B.: / /
2/18/06	S c/o nudily [illegible] x [illegible]
	O) [illegible]
	[illegible]
	[illegible] schedule
	A/P:
	[illegible]
	[illegible]
2/20/05	S c/o [illegible]
	O) [illegible]
	[illegible]
	[illegible]
	[illegible]
	A/P
	[illegible]

Date/Time	Inmate's Name: D.O.B.: / /
12/31/04	S wt Concern & Blood [illegible]
	O Doing well
	no apparent problems today
	A Concerned about w/
	P wt is [illegible], and his Blood
	[illegible] will be done very soon
	[signature]
12/14/04 8p	S c/o having HA and
	swollen [illegible]
	O [illegible]
	[illegible]
	no [illegible] heart
	[illegible]
	A/P [illegible]
	[illegible]
12/17/07	S/ c/o [illegible]
	O [illegible]
	[illegible]
1/25/05	S c/o [illegible]
	O [illegible]
	[illegible]
	A/P [illegible] [signature]

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: RESIDENTIAL TREATMENT UNIT (PETAEM)

Treatment Plan Reviewed on: August 7, 2003 Treatment Plan Initiated on: JUNE 14, 2003
Institution: BCCF Admitted to Unit on: JUNE 13, 2003
Level Currently assigned: 3

CURRENT STATUS

Problem #1

Target Date for Resolution:
Status: Resolved ☐ No Change ☐ Modified ☐
Outcome/Modification:

Problem #2 OVERREACTION of hostility toward an INMATE due to A Conflict (EXCHANGE of WORDS And ACCUSSED of hitting AN INMATE).
Target Date for Resolution: SEPTEMBER 1, 2003
Status: Resolved ☐ No Change ☐ Modified ☒
Outcome/Modification: - REFERRED to ANGER MANAGEMENT
- WILL HAVE ZERO EPISODES of Angry outburst

Problem #3 NONCOMPLIANCE with PRESCRIBED MEDICATION
Target Date for Resolution: SEPTEMBER 1, 2003
Status: Resolved ☐ No Change ☐ Modified ☒
Outcome/Modification: - REFERRED to MEDICATION EDUCATION

Comments: MR. WRIGHT REFUSED to ATTEND his COUNSELING SESSION AND REVIEW TREATMENT PLAN (DATE AND SIGN)

Level Change? Yes ☐ No ☒ New Level: _____

Second Page attached: Yes ☐ No ☒

Psychiatrist: Audrey Thomas-Crews Psychologist: M Clarke
Mental Health Nurse: [illegible] Activities Tech: [illegible]
Treatment Coordinator: L. Wells Correctional Officer Present: Yes ☐ No ☒

Inmate Agreement: REFUSED TO SIGN Date: _____
Next Treatment Plan Review to be Conducted by: _____ (Level 1: weekly; Level 2: bi-weekly; Level 3 & 4: monthly)
SEPTEMBER 1, 2003

Inmate Name	RICHARD WRIGHT	AIS #	187140

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: RESIDENTIAL TREATMENT UNIT (REVIEW)

Treatment Plan Reviewed on: July 9 2002 Treatment Plan Initiated on: June 14, 2002
Institution: Bullock County Correctional Facility Admitted to Unit on: June 12, 2002
Level Currently assigned: 2

CURRENT STATUS

Problem #1 Overreaction of hostility toward an inmate due to a conflict. Exchange of words and accussed of hitting an inmate.
Target Date for Resolution: August 1, 2002
Status: Resolved ☐ No Change ☐ Modified ☒
Outcome/Modification: Completed Anger Management group. Referred to Individual counseling only and Monitored on an individual basis. Objective is to maintain stability on the Residential Treatment Unit.

Problem #2
Target Date for Resolution:
Status: Resolved ☐ No Change ☐ Modified ☐
Outcome/Modification:

Problem #3
Target Date for Resolution:
Status: Resolved ☐ No Change ☐ Modified ☐
Outcome/Modification:

Comments:

Level Change? Yes ☒ No ☐ New Level: 3

Second Page attached: Yes ☐ No ☒

Psychiatrist: [signature] Psychologist: [signature]
Mental Health Nurse: [signature] Activities Tech: D. Hutchett
Treatment Coordinator: T. Willis Correctional Officer Present: Yes ☐ No ☒

Inmate Agreement: Richard W Wright Date: 9 July 02
Next Treatment Plan Review to be Conducted by: August 1, 2002 (Level 1: weekly; Level 2: bi-weekly; Level 3 & 4: monthly)

Inmate Name	AIS #
Richard Wright	187140

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: RESIDENTIAL TREATMENT UNIT (REVIEW)

Treatment Plan Reviewed on: June 24, 2002 Treatment Plan Initiated on: June 14, 2002
Institution: Bullock County - Cobb Facility Admitted to Unit on: June 13, 2002
Level Currently assigned: 3

CURRENT STATUS

Problem #1 Overreaction of hostility toward an inmate due to a conflict. Exchange of words and accused of hitting an inmate.
Target Date for Resolution: August 1, 2002
Status: Resolved ☐ No Change ☐ Modified ☒
Outcome/Modification: Mr. Wright has completed Anger Management group. The client reported that he is doing trash detail on 1st shift. In addition, client does not want to enroll in any groups, threat, client will be referred to Individual counseling only.

Problem #2
Target Date for Resolution:
Status: Resolved ☐ No Change ☐ Modified ☐
Outcome/Modification:

Problem #3
Target Date for Resolution:
Status: Resolved ☐ No Change ☐ Modified ☐
Outcome/Modification:

Comments:

Level Change? Yes ☒ No ☒ New Level: 4

Second Page attached: Yes ☐ No ☒

Psychiatrist: Audrey Dermen (CNP) Psychologist: [illegible]
Mental Health Nurse: [illegible] Activities Tech: D. Pritchett
Treatment Coordinator: T. Willis Correctional Officer Present: Yes ☐ No ☒

Inmate Agreement: Richard W Wright Date: 24 June 02
Next Treatment Plan Review to be Conducted by: July 2, 2002 (Level 1: weekly; Level 2: bi-weekly; Level 3 & 4: monthly)

Inmate Name: Richard Wright AIS #: 187140

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: RESIDENTIAL TREATMENT UNIT

Treatment Plan Initiated on: JUNE 14 2002 Treatment Coordinator: L. Willis
Institution: Bullock County Correctional Facility Admitted to RTU on: JUNE 13, 2002
Level Currently Assigned: 2

DSM IV Diagnosis:
Axis I: Schizoaffective Disorder, Manic
Axis II: Explosive Personality Disorder
Axis III: Deferred
Axis IV: Incarceration
Axis V: 70

Problem #1 Over reaction of hostility toward an inmate due to a conflict (Exchange of words and illusion of hitting an inmate)
Goal: Become Capable of handling Angry feelings in constructive ways
Target Date for Resolution: July 14 2002
Intervention(s): Mr. Wright has completed Anger Management group. The client reported that he is doing trash detail on 1st shift. In addition client does not want to complete any groups, therefore, client will be monitored on an individual basis.
Staff Member(s) Responsible: Ms. Willis Frequency: Biweekly review

Problem #2
Goal:
Target Date for Resolution:
Intervention(s):
Staff Member(s) Responsible: Frequency:

Problem #3
Goal:
Target Date for Resolution:
Intervention(s):
Staff Member(s) Responsible: Frequency:

Second Page attached: Yes ☐ No ☒

Psychiatrist: Audrey Norman, CRNP Treatment Coordinator: L. Willis
Mental Health Nurse: M Counts Activities Tech:
Correctional Officer Present: Yes ☐ No ☒

Inmate Agreement: Richard W Wright Date: 14 June 02
Treatment Plan Review to be Conducted by: July 2, 2002 (Level 1: weekly; Level 2: bi-weekly; Level 3 & 4: monthly)

Inmate Name	AIS #
Richard Wright	187140

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: RESIDENTIAL TREATMENT UNIT (REVIEW)

Treatment Plan Reviewed on: March 11, 2002 Treatment Plan Initiated on: August 16, 2001
Institution: Bullock County Corr. Facility Admitted to Unit on: July 17, 2001
Level Currently assigned: 4

CURRENT STATUS

Problem #1 Aggressive And Assaultive Behavior
Target Date for Resolution: May 4, 2002
Status: Resolved ☒ No Change ☐ Modified ☐
Outcome/Modification: Referred to Anger Management group. Objective is to verbalize feelings of anger in a controlled, assertive way

Problem #2 Incompletion of Requirements for High School diploma or GED
Target Date for Resolution: May 4, 2002
Status: Resolved ☒ No Change ☐ Modified ☐
Outcome/Modification: Referred to GED program. Objective is to identify the negative consequences that have occurred due to lack of high school diploma.

Problem #3 Alcohol And Drug History
Target Date for Resolution: May 4, 2002
Status: Resolved ☒ No Change ☐ Modified ☐
Outcome/Modification: Referred to Substance Abuse Program. Objective is to verbalize an understanding of personality, social, and family factors that foster chemical dependence.

Comments: Certificate for Anger Management
Certificate for Substance Abuse Program
Client has a High School diploma
Level Change? Yes ☐ No ☒ New Level: _____

Second Page attached: Yes ☐ No ☒

Psychiatrist: Cindy Bowman, NP-gnp Psychologist: [illegible]
Mental Health Nurse: [illegible] Activities Tech: [illegible]
Treatment Coordinator: T. Willis Correctional Officer Present: Yes ☐ No ☒

Inmate Agreement: Richard Wright Date: 11 MAR 02
Next Treatment Plan Review to be Conducted by: April 4, 2002 (Level 1: weekly; Level 2: bi-weekly; Level 3 & 4: monthly)

Inmate Name	AIS #
Richard Wright	187140

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: RESIDENTIAL TREATMENT UNIT (REVIEW)

Treatment Plan Reviewed on: March 4, 2002 Treatment Plan Initiated on: August 16, 2001
Institution: Bullock County Corr. Facility Admitted to Unit on: July 17, 2001
Level Currently assigned: 4

CURRENT STATUS

Problem #1 Difficulty controlling violent behavior.
Target Date for Resolution: May 4, 2002
Status: Resolved ☐ No Change ☐ Modified ☑
Outcome/Modification: Referred to Anger Management group. Objective is to verbalize feelings of anger in a controlled, assertive way.

Problem #2 Incompletion of Requirements for high school diploma or GED.
Target Date for Resolution: May 4, 2002
Status: Resolved ☐ No Change ☐ Modified ☑
Outcome/Modification: Referred to GED program. Objective is to identify the negative consequences that have occurred due to lack of high school diploma.

Problem #3 Alcohol and drug history.
Target Date for Resolution: May 4, 2002
Status: Resolved ☐ No Change ☐ Modified ☑
Outcome/Modification: Referred to Substance Abuse program. Objective is to verbalize an understanding of personality, social, and family factors that foster chemical dependence.

Comments:

Level Change? Yes ☐ No ☑ New Level: _____

Second Page attached: Yes ☐ No ☑

Psychiatrist: _____ Psychologist: _____
Mental Health Nurse: _____ Activities Tech: _____
Treatment Coordinator: T. Willis Correctional Officer Present: Yes ☐ No ☑

Inmate Agreement: Richard W Wright Date: 4 MAR 02
Next Treatment Plan Review to be Conducted by: April 4, 2002 (Level 1: weekly; Level 2: bi-weekly; Level 3 & 4: monthly)

Inmate Name	AIS #
Richard Wright	187140

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: INTENSIVE PSYCHIATRIC STABILIZATION UNIT

Treatment Plan Initiated on: 2/6/02 Treatment Coordinator: A. Mitchell, M.S.
Institution: KCF Admitted to Unit on: 2/5/02

DSM IV Diagnosis:
Axis I: Schizoaffective Disorder, Manic
Axis II: Deferred
Axis III: None
Axis IV: None
Axis V: Current GAF = 70 / HPY = 80

Problem #1 Pt does not feel like he needs medication.
Goal: Pt will verbalize an understanding of why he needs to remain compliant with his medication.
Target Date for Resolution: 3/6/02
Intervention(s): Medication education; Counseling re: tx compliance (individual & group)
Staff Member(s) Responsible: MHP's, nurses, DOC MH staff Frequency: daily

Problem #2 Pt has poor insight into his MI.
Goal: Pt will express an understanding of his MI, its tx, and how to prevent relapse.
Target Date for Resolution: 3/6/02
Intervention(s): Individual & group counseling
Staff Member(s) Responsible: MH staff Frequency: 3x/wk

Problem #3 Pt is harboring anger & resentment towards ADOC.
Goal: Pt will learn & demonstrate effective anger management techniques and will work towards resolving the underlying issues.
Target Date for Resolution: 3/6/02
Intervention(s): Individual & group counseling; anger management
Staff Member(s) Responsible: MH staff Frequency: 3x/wk

Second Page attached: Yes ☐ No ☒

Psychiatrist: _____ Psychologist: _____
Mental Health Nurse: _____ Activities Tech: _____
Treatment Coordinator: A. Mitchell, M.S. Correctional Officer Present: Yes ☐ No ☐
Inmate Agreement: Richard W Wright Date: Feb 06 2002

Treatment Plan Review to be Conducted by: _____ (within one week)

Inmate Name	AIS #
Wright, Richard	187140

Group Name: Values Clarification & Decision-Making (Pt. I) Date/Time: 2/27/02 10:00

Dress/Grooming:	(Appropriate)	Marginal	Disheveled		
Motor Activity:	Decreased	Agitation	Tremors	(Appropriate)	
General Attitude/Behavior:	(Spontaneous) (Participated)	Preoccupied / Passively Attentive	Suspicious / Inattentive	Argumentative / Disruptive	Withdrawn / Hostile
Mood/Affect:	Flat	Depressed	Euphoric	Anxious	(Unremarkable)
Speech:	(Normal)	Slurred	Rapid	Talkative	Mute
Flight of Ideas:	Confabulation	Tangential	Loose Associations	(None)	
Thought Content:	Suicidal Thought/Plans	Homicidal Thought/Plans	Bizarre	Obsessive	Suspicious
	Inadequacy	Poverty of Content	(No deficit identified)	Helplessness	
Delusions:	(None)	Persecution	Systematized	Somatic	
Hallucinations:	(None)	Auditory	Visual		
Insight/Judgment:	Unimpaired	(Poor Judgment)	Poor Insight		

Group Leaders Name & Signature: A. Mitchell, M.S.

Group Name: Values Clarification & Decision-Making (Pt. II) Date/Time: 2/27/02 1:00

Dress/Grooming:	(Appropriate)	Marginal	Disheveled		
Motor Activity:	Decreased	Agitation	Tremors	(Appropriate)	
General Attitude/Behavior:	(Spontaneous) (Participated)	Preoccupied / Passively Attentive	Suspicious / Inattentive	Argumentative / Disruptive	Withdrawn / Hostile
Mood/Affect:	Flat	Depressed	Euphoric	Anxious	(Unremarkable)
Speech:	(Normal)	Slurred	Rapid	Talkative	Mute
Flight of Ideas:	Confabulation	Tangential	Loose Associations	(None)	
Thought Content:	Suicidal Thought/Plans	Homicidal Thought/Plans	Bizarre	Obsessive	Suspicious
	Inadequacy	Poverty of Content	(No deficit identified)	Helplessness	
Delusions:	(None)	Persecution	Systematized	Somatic	
Hallucinations:	(None)	Auditory	Visual		
Insight/Judgment:	Unimpaired	(Poor Judgment)	Poor Insight		

Group Leaders Name & Signature: A. Mitchell, M.S.

Name: Wright, Richard AIS: 187140

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: INTENSIVE PSYCHIATRIC STABILIZATION UNIT *(REVIEW)*

Treatment Plan Reviewed on: 2/13/02 Treatment Plan Initiated on: 2/6/02
Institution: KCF Admitted to Unit on: 2/5/02

CURRENT STATUS:

Problem #1 Pt does not feel like he needs medication.
Target Date for Resolution: 3/6/02
Status: Resolved ☐ No Change ☒ Modified ☐
Outcome/Modification:
Staff Member(s) Responsible: MHP's, nurses, DOC, MH staff Frequency: daily

Problem #2 Poor insight into MI.
Target Date for Resolution: 3/6/02
Status: Resolved ☐ No Change ☒ Modified ☐
Outcome/Modification:
Staff Member(s) Responsible: MH staff Frequency: 3x/wk

Problem #3 Anger/resentment towards ADOC.
Target Date for Resolution: 3/6/02
Status: Resolved ☐ No Change ☒ Modified ☐
Outcome/Modification:
Staff Member(s) Responsible: MH staff Frequency: 3x/wk

Comments:

Plan if inmate not stabilized within 30 days of admission:

Second Page attached: Yes ☐ No ☐

Psychiatrist: _____ Psychologist: _____
Mental Health Nurse: _____ Activities Tech: _____
Treatment Coordinator: A. Mitchell, M.S. Correctional Officer Present: Yes ☐ No ☐

Inmate Agreement: Richard W Wright Date: 13 Feb 02
Next Treatment Plan Review to be Conducted by: (within one week)

Inmate Name	Wright, Richard	AIS #	187140

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: INTENSIVE PSYCHIATRIC STABILIZATION UNIT (REVIEW)

Treatment Plan Reviewed on: 2/20/02 Treatment Plan Initiated on: 2/6/02
Institution: KCF Admitted to Unit on: 2/5/02

CURRENT STATUS:

Problem #1 Noncompliance c medication.

Target Date for Resolution: 3/6/02
Status: Resolved ☐ No Change ☒ Modified ☐
Outcome/Modification: 3

Staff Member(s) Responsible: MH Nurses, Psychiatrist, DOC Frequency: daily

Problem #2 Poor insight into his MI.

Target Date for Resolution: 3/6/02
Status: Resolved ☐ No Change ☒ Modified ☐
Outcome/Modification:

Staff Member(s) Responsible: MH staff Frequency: 3x/wk

Problem #3 Pt seems angry/resentful towards ADOC.

Target Date for Resolution: 3/6/02
Status: Resolved ☐ No Change ☐ Modified ☒ Improved.
Outcome/Modification:

Staff Member(s) Responsible: MH staff Frequency: 3x/wk

Comments:

Plan if inmate not stabilized within 30 days of admission:

Second Page attached: Yes ☐ No ☐

Psychiatrist: Psychologist:
Mental Health Nurse: Activities Tech:
Treatment Coordinator: A. Mitchell, M.S. Correctional Officer Present: Yes ☐ No ☐

Inmate Agreement: Richard W Wright Date: 20 Feb 02
Next Treatment Plan Review to be Conducted by: (within one week)

Inmate Name	Wright, Richard	AIS #	187140

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: INTENSIVE PSYCHIATRIC STABILIZATION UNIT (REVIEW)

Treatment Plan Reviewed on: 2/28/02 Treatment Plan Initiated on: 2/6/02
Institution: KCF Admitted to Unit on: 2/5/02

CURRENT STATUS:

Problem #1 Noncompliance w meds.
Target Date for Resolution: 3/6/02
Status: Resolved ☐ No Change ☒ Modified ☐
Outcome/Modification:
Staff Member(s) Responsible: MH Nurses, Psychiatrist, DOC Frequency: daily

Problem #2 Poor insight into his MI.
Target Date for Resolution: 3/6/02
Status: Resolved ☐ No Change ☐ Modified ☒ Improved.
Outcome/Modification:
Staff Member(s) Responsible: MH staff Frequency: 3x/wk.

Problem #3 Anger/resentment towards DOC.
Target Date for Resolution:
Status: Resolved ☒ No Change ☐ Modified ☐
Outcome/Modification:
Staff Member(s) Responsible: MH staff Frequency: 3x/wk

Comments:

Plan if inmate not stabilized within 30 days of admission:

Second Page attached: Yes ☐ No ☐

Psychiatrist: Psychologist:
Mental Health Nurse: Activities Tech:
Treatment Coordinator: A. Mitchell, M.S. Correctional Officer Present: Yes ☐ No ☐

Inmate Agreement: Richard W Wright Date: 28 Feb 02
Next Treatment Plan Review to be Conducted by: (within one week)

Inmate Name	AIS #
Wright, Richard	187140

2/18/02 AM

HOW TO PRESENT INFORMATION ABOUT PATIENT

Name: Richard Wright #187140

Age: 34

Race: B

Gender: M

Crime: Burglary I c victim injury

Sentence: 25

History: No past SI or attempts
Recent assault on inmate
No MH history prior to incarceration.
(1 yr ago - Drap

Diagnosis:

AXIS I - Schizoaffective Disorder, Manic — Paranoia, Grandiosity, AH

AXIS II - Deferred
AXIS III - None
AXIS IV - None
AXIS V - Current GAF = 70; HPY = 80

Medication and compliance: Prolixin / Cogentin
Says he doesn't need it

Problems at this time: Noncompliance c Meds.

Plan: Sleepy? Eval. c medical.

AUG 16 2001

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: RESIDENTIAL TREATMENT UNIT

Treatment Plan Initiated on: 8/16/01 Treatment Coordinator: Hixon
Institution: Bullock Admitted to RTU on: 7/17/01
Level Currently Assigned: 4

DSM IV Diagnosis:
Axis I: Schizoaffective Disorder
Axis II: Borderline Personality Disorder
Axis III: none (current)
Axis IV: incarceration
Axis V: 40 (current)

Problem #1 Anger / past violent behavior
Goal: Help pt. to learn effective management for
Target Date for Resolution:
Intervention(s): Refer to anger man - anger agement group.
Staff Member(s) Responsible: Hixon Frequency: 3X week

Problem #2 Pt. wants to get renedial help with Math & English.
Goal: Help Pt. Get into renedial classes
Target Date for Resolution: end
Intervention(s): Refer pt. for renedial classes
Staff Member(s) Responsible: Hixon Frequency: weekly

Problem #3
Goal:
Target Date for Resolution:
Intervention(s):
Staff Member(s) Responsible: Frequency:

Second Page attached: Yes ☐ No ☑

Psychiatrist: Treatment Coordinator: Hixon
Mental Health Nurse: Activities Tech:
Correctional Officer Present: Yes ☐ No ☐

Inmate Agreement: Richard W Wright Date: 8/16/2001
Treatment Plan Review to be Conducted by: (Level 1: weekly; Level 2: bi-weekly; Level 3 & 4: monthly)

Inmate Name	AIS #
Wright, Richard	187140

NAPHCARE
Annual Health and TB Screening for Inmates

Facility Bullock

Date Given: 4-15-02 Date Read 4-17-02

Site Given: LFA Size in M.M. 0

Lot# 45256261

Nurse Martha Jackson Nurse Martha Jackson LPN

Note: **Past Positives and conversions**, use Assessment of Tuberculin status for PPD reactors form *in addition to completing the bottom of this form.*

I have received a fact sheet on TB and have had the opportunity to have my questions answered. I agreed to testing by PPD. I understand the PPD must be read 72 hours after being administered. I have never had a positive reaction to a TB skin test, nor have I ever been treated with TB drugs. I have also been instructed to check with my regular physician or the public health department if I am released prior to the TB test being read.

Current Weight 213 Previous Weight 184 B/P 140/80

	circle
Recent chest pain	Yes or (No)
Kitchen clearance assess. done and attached	Yes or (No)
Productive cough	Yes or (No)
Any bleeding	Yes or (No)

Emergency contact Susie Oliver Phone# 334-749-1742

Address 223 Vera Court
Opelika, Al.

Inmate signature Richard W Wright Date 4-15-02

Witness signature Martha Jackson Date 4-15-02

DOB 8-15-67 AGE 34 Race B/C SEX Male SSN 083-58-5792

Inmate Name Wright Richard AIS# 187140

PERIODIC HEALTH ASSESSMENT

I. HISTORY - (Nurse)

	YES	NO	COMMENTS
Weight Change (>15 lb.) (Compare Weight Below)	___	✓	Last Weight at least 6 mo.'s. ago: ___
Persistent Cough	___	✓	
Chest Pain	___	✓	
Blood In Urine or Stool	___	✓	
Difficult Urination	___	✓	
Other Illnesses (Details)	___	✓	
Smoke, Dip or Chew	___	✓	
ALLERGIES	___	✓	

Weight 184 Temp. 97.6 Pulse 78 Resp. 20 B.P. 110/80

Eye Exam: Without Glasses OD 20/50 OS 20/70 OU 20/50

With Glasses OD ___ OS ___ OU ___

Wears glasses but did not bring them

II. TESTING - (Nurse)

	RESULTS
Tuberculin Skin Test (q yr.)	Date Given 7/4/00 Site LFA RFA R Forearm
(chest x-ray if clinical symptoms)	Read On 7/6/00 Results 0 mm
RPR (q 3 yrs.)	Date 7/21/99 Results NR
Urine Dip (yearly)	Results ~~A.B Neg~~ 7/8/00 +30 protein
(Glu., Pro., RBC., WBC.)	
EKG (baseline at 35, over 45 q 3 yrs.)	N/A
Cholesterol (at 35 then q 5 yrs.)	N/A
Tetanus/Diphtheria (q 10 yrs.)	Last Given 5/20/96 Due 2006
If Done Today:	Site Given ___ Dose ___ Lot # ___
Mammogram – (Annually - Females > 49)	Date Done N/A Results ___

III. PHYSICAL

	RESULTS
Heart	NSR
Lungs	Clear
Breast (q 2 yrs. p 30)	Date N/A Results ___
Rectal (yearly p 45)	Results N/A Hemocult ___
Pelvic and PAP (q 1 yr.)	Date N/A Results ___

Inmate Name Wright, Richard AIS # 187140

DOB 8/15/67 Age 32 Race B Sex M SSN 083 58 5792

Emergency Addressee Aunt Susan Oliver Phone # 334-249-1742

Address 223 Hero Ct Opelika AL 36801

Facility DCC Nurse Signature [signature] Date 7/8/2000

Physician Signature ___ Date ___

TUBERCULIN PPD FOR INM ES

INITIAL SKIN TEST

Date Given: 7/14/00 Date Read: 07/16/00

Site Given: LFA Size: 0 mm

Lot #: C0148AA

Nurse: AH Smith hpa Nurse: MWilliams RN

I have received a fact sheet on TB and have had the opportunity to have my questions answered. I agreed to TB testing by PPD. I understand the PPD must be read 72 hours after being administered. I have never had a positive reaction to a TB skin test, nor have I ever been treated with TB drugs. I have also been instructed to check with my regular physician or the public health department if I am released prior to the TB test being read.

Richard W Wright — 14 July 00

Inmate Signature — Date

AH Smith hpa — 7/14/00

Witness Signature — Date

INMATE NAME:	ID#:	RACE:	LOCATION:
Wright, Richard	187140	Bm	DCC

TUBERCULIN PPD FOR INM. 75

INITIAL SKIN TEST

Date Given: 7/8/2000 | Date Read: 7/10/2000

Site Given: L/A FRm | Size: 0 mm

Lot #: C0148AA

Nurse: M Sloan LPN | Nurse:

I have received a fact sheet on TB and have had the opportunity to have my questions answered. I agreed to TB testing by PPD. I understand the PPD must be read 72 hours after being administered. I have never had a positive reaction to a TB skin test, nor have I ever been treated with TB drugs. I have also been instructed to check with my regular physician or the public health department if I am released prior to the TB test being read.

Richard W. Wright — Inmate Signature

8 July 2000 — Date

M Sloan LPN — Witness Signature

7/8/2000 — Date

INMATE NAME:	ID#:	RACE:	LOCATION:
Wright Richard	187140	B/M	D&C

PERIODIC HEALTH ASSESSMENT

I. HISTORY - (Nurse)	YES	NO	COMMENTS
Weight Change (>15 lb.) (Compare Weight Below)	___	✓	Last Weight at least 6 mo.'s. ago: ___
Persistent Cough	___	✓	
Chest Pain	___	✓	
Blood In Urine or Stool	___	✓	
Difficult Urination	___	✓	
Other Illnesses (Details)	___	✓	
Smoke, Dip or Chew	___	✓	
ALLERGIES	✓	___	poison ivy

Weight 185 Temp. 98.6 Pulse 60 Resp. 16 B.P. 110/84

Eye Exam: Without Glasses OD 20/70 OS 20/70 OU 20/50

With Glasses OD ___ OS ___ OU ___

II. TESTING - (Nurse)	RESULTS
Tuberculin Skin Test (q yr.)	Date Given 7/17/99 Site L FA
(chest x-ray if clinical symptoms)	Read On 7/19/99 Results 0 mm
RPR (q 3 yrs.)	Date 7/17/99 Results NR
Urine Dip (yearly) (Glu., Pro., RBC., WBC.)	Results 7/17/99 WNL
EKG (baseline at 35, over 45 q 3 yrs.)	N/A
Cholesterol (at 35 then q 5 yrs.)	N/A
Tetanus/Diphtheria (q 10 yrs.)	Last Given 5-20-96 Due 2006
If Done Today:	Site Given ___ Dose ___ Lot # ___
Mammogram – (Annually - Females > 49)	Date Done N/A Results ___

III. PHYSICAL	RESULTS
Heart	RRR
Lungs	clear
Breast (q 2 yrs. p 30)	Date N/A Results ___
Rectal (yearly p 45)	Results N/A Hemocult ___
Pelvic and PAP (q 1 yr.)	Date N/A Results ___

Inmate Name Wright, Richard AIS # 187140

DOB 8-15-67 Age 31 Race B Sex M SSN 083 58 5792

Emergency Addressee Susie Olive Phone #334 749 1742

Address 223 Zero Ct Opelika, AL

Facility DCC Nurse Signature M Woodfin RN Date 7/17/99

Physician Signature [signature] Date ___

8/1/98

TUBERCULIN PPD FOR ENM ES

INITIAL SKIN TEST

Date Given: 7/17/99 Date Read: 7/19/99

Site Given: LFA Size: 0 mm

Lot #: 2503-11

Nurse: K Merriweather LPN Nurse: [signature] LPN

I have received a fact sheet on TB and have had the opportunity to have my questions answered. I agreed to TB testing by PPD. I understand the PPD must be read 72 hours after being administered. I have never had a positive reaction to a TB skin test, nor have I ever been treated with TB drugs. I have also been instructed to check with my regular physician or the public health department if I am released prior to the TB test being read.

Richard W. Wright 7/17/99
Inmate Signature Date

K. Merriweather 7/17/99
Witness Signature Date

INMATE NAME:	ID#:	RACE:	LOCATION:
Wright, Richard	187140	Bm	DCC

PERIODIC HEALTH ASSESSMENT

I. HISTORY - (Nurse)	YES	NO	COMMENTS
Weight Change (>15 lb.) (Compare Weight Below)	___	✓	Last Weight at least 6 mo.'s. ago: 190# yr. ago
Persistent Cough	___	✓	
Chest Pain	___	✓	
Blood In Urine or Stool	___	✓	
Difficult Urination	___	✓	
Other Illnesses (Details)	___	✓	
Smoke, Dip or Chew	___	✓	
ALLERGIES	___	✓	(Poison Ivy)

Weight 188 Temp. 97.3 Pulse 86 Resp. 18 B.P. 120/98

Eye Exam: Without Glasses OD N/A OS N/A OU N/A
With Glasses OD N/A OS N/A OU N/A

II. TESTING - (Nurse)	RESULTS
~~*~~ Tuberculin Skin Test (q yr.) (chest x-ray if clinical symptoms)	Date Given 7/26/98 Site Lt. forearm Read On 7/28/98 Results 0mm mm
RPR (q 3 yrs.)	Date 5/20/96 Results NR
* Urine Dip (yearly) (Glu., Pro., RBC., WBC.)	Results 7/26/98 Negative x 4
EKG (baseline at 35, over 45 q 3 yrs.)	N/A
Cholesterol (at 35 then q 5 yrs.)	N/A
Tetanus/Diphtheria (q 10 yrs.)	Last Given 5/20/96 Due 2006
If Done Today:	Site Given N/A Dose N/A Lot # N/A

III. PHYSICAL	RESULTS
Heart	Regular and Even
Lungs	Clear
Breast (q 2 yrs. p 30)	Date N/A Results N/A
Rectal (yearly p 45)	Results — N/A
With Hemocult	Results N/A
Pelvic and PAP (q 1 yr.)	Date N/A Results N/A

Inmate Name Wright Richard AIS # 187140
DOB 8/15/67 Age 30 Race BLK Sex M SSN 083-58-5792
Emergency Addressee Susie Oliver Phone # (334) 749-1742
Address 223 Vera Court Opelika AL. 36801
Facility BCCF Nurse Signature Daniel LPN Date 7/26/98
Physician Signature [signature] Date 7/26/98

TUBERCULIN PPD FOR INMATES

INITIAL SKIN TEST			
Date Given:	7/26/98	Date Read:	7/28/98
Site Given:	Lt. forearm	Size:	0mm mm
Lot #:	2468-11		
Nurse:	CFaniel/pw	Nurse:	CFaniel/pw

I have received a fact sheet on TB and have had the opportunity to have my questions answered. I agreed to TB testing by PPD. I understand the PPD must be read 72 hours after being administered. I have never had a positive reaction to a TB skin test, nor have I ever been treated with TB drugs. I have also been instructed to check with my regular physician or the public health department if I am released prior to the TB test being read.

Richard W Wright — Inmate Signature — 7/26/98 — Date

CFaniel/pw — Witness Signature — 7/26/98 — Date

INMATE NAME:	ID#:	RACE:	LOCATION:
Wright Richard	187140	Blk	BCCF

PERIODIC HEALTH ASSESSMENT

I. HISTORY	YES	NO	COMMENTS
PERSISTENT COUGH		✓	
CHEST PAIN		✓	
BLOOD IN URINE/STOOL		✓	
DIFFICULT URINATION		✓	
ALLERGIES TO MEDS		✓	
SMOKING		✓	
OTHER ILLNESS (DETAILS)			

II. PHYSICAL	RESULTS
HEART	WNL
LUNGS	WNL
WEIGHT 190 BP 128/88 PULSE 84	
RECTAL WITH HEMOCULT (yearly p 45)	

III. TESTING	RESULTS
TUBERCULIN SKIN TEST (q yr.)	DATE GIVEN 5/2/97 READ 8/4/97
	RESULTS 0 mm
URINE DIP (yearly)	TLC.
RPR (q 3 yrs.)	DATE 5-20-96 RESULTS NR
EKG (baseline @35, over 45, q 3 yrs)	
CHOLESTROL (q 5 yrs.)	
TETANUS/DIPTHERIA (q 10 yrs)	5-20-96

NURSE'S SIGNATURE [signature] DATE 5/2/97

FACILITY Draper PHYSICIAN'S SIGNATURE KM&MD

DOB 8-15-67 AGE 29 RACE B SEX M

INMATE'S NAME Wright, Richard AIS# 187140

CORRECTIONAL MEDICAL SERVICES
MEDICAL HISTORY AND SCREENING

INMATE NAME:	ID #:	RACE:	D.O.B.:
Wright, Richard W.	187140	B/M	8-15-67

INMATE QUESTIONNAIRE

		(circle one)
1. Do you have a medical problem such as bleeding or injuries that requires immediate medical attention?	Yes	No
2. Have you fainted or had a head injury within past six months?	Yes	No
3. Are you allergic to any medications?_____	Yes	No
4. Have you been seen by a doctor in the past six months?	Yes	No
5. Do you wear dentures or partial plate?_____	Yes	No
6. Do you wear glasses or contact lenses?	Yes	No
7. Do you have a prosthesis, splint, crutches, cast or brace that you need while here?	Yes	No
8. Do you drink wine, beer or whiskey? How often? 2-3 day (weekends) How much? 12 + 18 pack Last time? Oct. 1995	Yes	No
9. Have you had seizures or blackouts when you stop drinking?	Yes	No
10. Do you use drugs? Type? _____ How often? _____ Last time? _____	Yes	No
11. Have you had withdrawal problems when you stop taking drugs?	Yes	No
12. Do you have any medical problems we should know about?	Yes	No
13. Are you covered by medical insurance or a benefits program?	Yes	No
14. Have you been in this facility before?	Yes	No
FEMALE INMATES ONLY		
1. Are you pregnant?	Yes	No
2. Do you use birth control? Type? _____	Yes	No
3. Have you recently had a baby, miscarriage or abortion?	Yes	No

COMMENTS: (Explain "Yes" responses)
#4. Headaches - B/P problems

DISPOSITION

Referrals ___ None
___ Emergency Room (Pre-booking injury)
___ Emergency Room (Acute condition)
___ Physician
___ Sick Call

Placement
___ Infirmary
___ Detoxification Setting
___ General Population
___ Other

CURRENT MEDICAL CONDITIONS (circle terms that apply)

Unconscious	Skin Infestation
Intoxicated	Restricted Mobility
Lesions	Skin Rash
Obvious Pain	Jaundice
Bruises	Needle Marks
Fever	Swollen Glands
Nausea	Active Cough
Uses Tobacco	Vaginal/Penile Discharge

MEDICAL HISTORY (circle terms that apply)

Arthritis	Frequent Diarrhea
Diabetes	Genital Sores
Seizure Disorder	V.D.
Asthma	Hepatitis
Special Diet	HIV+
Heart Condition	Tuberculosis
Hypertension	Persistent Sore Throat
Stomach Ulcer	Dental Problems
Cancer	Surgeries
Sickle Cell Anemia	Chest Pain
Emphysema	Jaundice

TB SCREENING

Ever treated with TB Drugs? Yes No
PPD test? Yes No Positive Reaction? Yes No
When: Nov. 95
Where: Lee Co Jail

Chronic Cough/Blood	Fever
Recent Weight Loss	Night Sweats
Recent Appetite Loss	Fatigue

MEDICATIONS

Current medications:
Unk - B/P unknown

Prescriber:

ALLERGIES

Medication Allergies Yes No
Type: _____
Other Allergies Yes No
Type: _____

VITAL SIGNS

HT _____ WT _____ BP 140/80
Pulse _____ Resp. _____ Temp. _____

I acknowledge that I have answered all questions truthfully and have been told the way to obtain health services and consent to routine care provided by facility healthcare professionals. I understand that any medications not picked up within 30 days of release will be destroyed.

Inmate signature: Richard W Wright

SCREENED BY: Melonia Dreyfus DATE: 5/30/96 TIME: 8:15 AM

REVIEWED BY: _____ DATE: _____ TIME: _____

PHYSICAL ASSESSMENT

INMATE NAME:	ID #:	RACE:	D.O.B.:
Wright, Richard W.	187140	B/M	8-15-67

TYPE OF ASSESSMENT: INTAKE: ✓ OTHER: _____

FAMILY HISTORY: (f/father, m/mother, b/brother, s/sister)

TB ___	Hepatitis ___	HIV+___	Hypertension M
Cancer ___	Asthma ___	Epilepsy/	Anemia ___
Kidney Disease ___	Sickle Cell ___	Seizures ___	Mental Illness ___
Diabetes ___	Heart Disease ___	Other _____	

PHYSICAL EXAMINATION

Normal/Not Present Please ✓	Abnormal/Comment
SKIN: Color, Condition, Turgor, Recent injury, Tatoos, Scars	✓ scars
HEAD: Hair, Scalp (pediculi)	
EARS: Appearance, Canals	
EYES: Pupils, Sclera, Conjunctiva	
MOUTH: Throat, Tongue, Tonsils	
NOSE: Obstruction, Drainage	
NECK: Veins, Mobility, Thyroid, Carotids, Lymph nodes	
CHEST (BREASTS) Configuration, Auscultation, Respirations, Cough/Sputum	
HEART: Auscultation, Radial pulses, Apical pulse, Rhythm	
EXTREMITIES: Pulses, Edema, Joints	
SPINE	
REFLEXES	
ABDOMEN: Shape, Bowel sounds, Palpation, Hernia	
ANUS/RECTUM Hemorrhoids, Anal warts	
PELVIC	NA

VITAL SIGNS

HT 5'11" WT 186 BP _____

Pulse _____ Resp. _____ Temp. _____

VISION (SNELLEN CHART)	GROSS HEARING
Rt: 20/30 with glasses _____	Rt: _____
Lt: 20/25 with glasses _____	Lt: _____

DENTAL SCREENING

No. of missing teeth _____
Condition of teeth: poor fair good
Condition of gums: poor healthy
False teeth: partial plate upper lower
Oral Hygiene instructions given: _____

IMMUNIZATION STATUS

Date last Tetanus: 5-20-96
Other: _____

TB SCREENING

PPD:
Date/Time administered: 5-20-96
Date/Time read: 5-23-96
Results (millimeters): _____
Referral for chest x-ray: _____
_____ Yes _____ No

LABORATORY TESTS

	DATE OBTAINED
RPR:	5-20-96 NR
G.C.:	
PAP:	
HIV:	5-20-96 done
PREGNANCY TEST:	
OTHER:	

COMMENTS

REFERRAL sick call per front page

Assessed by: M Jacumer
Date: 5-24-96 Time: pm
Physician Review: _____
Date: _____ Time: _____

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
4-10-03		Tx Review note: S: Continues to voice concern c placement in general population. No problems or complaints reported. Although inmate has hx of non compliance c tx. Inmate verbally agreed to to follow tx recommendation for best interest although he voiced that he rather not take medication. O: Alert + coherent normal mood + affect. No signs of abnormal behavior. Speech + thought clear. A: appears stable without medication. P: ① Monitor stability [illegible] to [illegible] as needed ② Will consider for outpatient status if compliant c tx recommendation + positive behavior	Brown M.S.
4-25-03		Activity Tech: Monthly Activity Note: Inmate was offered a number of recreational activities in the month March. He failed to participate in any of the [illegible] Activities.	[illegible signature]
6/10/03		[illegible] to [illegible] [illegible]. No [illegible] [illegible] Approach [illegible]	[illegible signature]

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Wright, Richard	187140		B/M	BCCF

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INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
2-14-03		Activity Tech: Monthly Activity Note: Pt was offered a number of recreational activities in the month of January, including Open Recreation and Mental Stimulation Workshops. He did not participate in any of these activities. We will continue to offer therapeutic and recreational activities.	
3-31-03		Activity Tech: Monthly Activity Note: Pt was offered a number of recreational activities in the month of February; he did not participate in any of these activities. We will continue to offer therapeutic and Recreational activities.	
3-31-03		Tx Coordinator Note: S/D Pt recently assigned to Mr. Brown caseload. Contact made c pt in dorm. "I don't know why I'm here I rather be in population or another camp" Pt reports on no meds. Alert, oriented x3 (where & moral offense) No signs of ~~staff~~ w/d distress A: Stable P: Will meet next wk for tx planning — Bm M.I —	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Wright, Richard	187140		B/M	BCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
12-30-02		Activity Tech: Monthly Activities Note: Pt was offered a Number of therapeutic and recreational activities in the Month of November including, Bingo, Open Activity and Mental Stimulation Worksheets. He did not participate in any of the above offered activities. We will Continue to offer therapeutic and recreational activities.	
12/30/02		Refuse Mtt Services Hegji, MS	
1-17-03		Activity Tech: Monthly Activity Note. Pt was offered a number of recreational activities in the month of December, he failed to participate in any of the Mental Health Services. We will Continue to offer therapeutic and recreational activities.	
1-24-03		Psych eval. Cont. to refuse psych services. No management problem. Pleasant. Denies H/O. all meds D/C. — Worman, CPNP	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Wright, Richard	187140		M	BCF

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INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
7/30/2002	1:30	Treatment Coordinator Note: Continued Investigation. The client next review will be conducted by September 9, 2002. T. Wills, M.S.	
8/22/02		Involuntary Medication Review: Inmate Wright was reviewed (records and seen at cell. He had ~~been~~ ~~been~~ decompensated and was not overtly disturbed. Decompensation may be secondary ~~to~~ increased stress conditions. Committee did not agree to medicate involuntarily but recommended therapy and meds should be pursued. Wadley MD	
8-22-02		A strong case for forced medication was not made due to the D's ability to show self-control. M. Hamm MH	
8/23/2002	7:45	Treatment Coordinator Note: Correspondence received from Mr. Wright. T. Wills, M.S.	
9/5/02		Alert & oriented. No affective or thought impairment. Says Pt's filing suit from trouble. - Audrey Dorman, LPN	
10/25/02		Refused intervention. - Audrey Dorman, LPN	
11/12/02		Refused to see MHP. Yeager, M.S.	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Wright, Richard	187140		B/M	BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
8/16/02		Psychology Note. Mr Wright was seen yesterday (8/15/02) while he was receiving a medical evaluation prior to segregation placement for study a corrections officer. At that time his speech was rapid and included seemingly delusional references to his prosecutor and religious images. He was coincidentally scheduled for his next injection on that date which he refused. Mr Wright was seen today (8/16/02) & Dr Sanders in his segregation cell to determine the need for emergency medication. He was behaviorally controlled but continued to voice a high level of suspicion/paranoia related to DOC officials and mental health treatment staff. Although emergency meds did not seem warranted he will be considered for review for forced medication next week. Will continue to monitor — McCh	
8/20/02		Mr. WRIGHT manifest anergy, Defiant, Paranoid ATTITUDE is Sy. Scheduled for Brief Mental Health Review	
8/30/02	1:30	TREATMENT Coordinator Note: BIWEEKLY REVIEW update: MR. WRIGHT is CURRENTLY in the SEGREGATION Unit Pending —	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Wright Richard	187140	35	B/M	BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
8-2-02		S/O: Remains off all meds. + continues to deny any mental health issues. Hx. of bizarre behavior at Limestone: masturbating openly, loudly preaching "the word", and pouring water on self. He admits actions, but says that does not make him crazy. Previously took Prolixin + according to inmate, caused nightmares. Denies A/V hallucination. Remains somewhat suspicious + reportedly quick to anger. — also reports to be "very concerned about cleanliness". He denies sleep difficulty + reports appetite as good. Affect bright/smiling. Calm. Cooperative. — Hx: diagnosis: Schizoaffective disorder. — A: Stable now. Potential for harm to others. P: Monitor, intervene as needed. — No meds. for now. — Audrey Dorman, CPNP	
8-6-02		Prolixin Dec Injection scheduled for today - MR. wright refused - did not come to infirmary for inject - Reported to MAP - ms. willis. —	
8/7/2002	10:46	TREATMENT Coordinator Note: Mr. Wright REFUSED to attend his counseling session And REVIEW treatment plan (Sign And dated). Next REVIEW will be conducted by SEPTEMBER 8, 2002. — T. Willis, M.S.	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Wright, Richard	187140		B/M	BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
7/9/2002	13:00	TREATMENT COORDINATOR NOTE: CONTINUED SESSION. PROBLEM #1 - MODIFIED - OVERREACTION OF HOSTILITY TOWARD AN INMATE DUE TO A CONFLICT - EXCHANGE OF WORDS AND ACCUSSED OF HITTING AN INMATE - REFERRED TO ANGER MANAGEMENT GROUP (ABUSES) - OBJECTIVE IS TO MAINTAIN STABILITY ON THE RTU AND COMPLY WITH PRESCRIBED MEDICATION. MR. WRIGHT NEXT MONTHLY REVIEW WILL BE CONDUCTED BY AUGUST 9, 2002. I. WILLIS, M.S.	
7/18/02		INMATE REFUSED PROLIXIN DEC. INJECTION - NON COMPLIANT W/ ANY OF MEDICATION - WILL REF. TO MHC & MS. COURTS - WT 202 ——— VSlocks CA	
7/23/2002	10:34	TREATMENT COORDINATOR NOTE: CONTACT WITH RICHARD WRIGHT FOR BI-WEEKLY REVIEW AND INDIVIDUAL COUNSELING SESSION. MR. WRIGHT REPORTED A CONFLICT WITH AN INMATE WHICH WAS RESOLVED - IS WORKING TRASH DETAIL (3 DAYS OFF AND ON) - AND REFUSES TO TAKE MEDICATION, CLIENT REPORTED THAT HE IS WELL AND DOES NOT NEED MEDICATION. THE CLIENT NEXT REVIEW WILL BE CONDUCTED BY AUGUST 6, 2002. I. WILLIS	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Wright, Richard	187140		B/M	BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
6/14/2002	9:17	TREATMENT COORDINATOR NOTE: CONTINUED ACTIVITIES. THEREFORE, MR. WRIGHT WILL BE MONITORED ON AN INDIVIDUAL BASIS AND THE OBJECTIVE IS TO MAINTAIN STABILITY ON THE RTU. THE CLIENT NEXT BIWEEKLY REVIEW WILL BE CONDUCTED BY JULY 3, 2002 (LEVEL 2). T. WILLIS, M.S.	
6/24/2002	10:39	TREATMENT COORDINATOR NOTE: CONTACT WITH RICHARD WRIGHT FOR BIWEEKLY TREATMENT PLAN REVIEW AND INDIVIDUAL COUNSELING SESSION. PROBLEM # 1 (Modified) OVERREACTION OF HOSTILITY TOWARD AN INMATE DUE TO A CONFLICT OVER THE TELEVISION. MR. WRIGHT WAS REFERRED TO ANGER MANAGEMENT GROUP BUT HAS ALREADY COMPLETED GROUP SUCCESSFULLY. THEREFORE, CLIENT WILL BE REFERRED TO INDIVIDUAL COUNSELING ONLY AND THE GOAL IS TO MAINTAIN STABILITY ON THE RESIDENTIAL TREATMENT UNIT. MR. WRIGHT NEXT BIWEEKLY REVIEW WILL BE CONDUCTED BY JULY 2, 2002. T. WILLIS, M.S.	
7/9/2002	13:00	TREATMENT COORDINATOR NOTE: CONTACT WITH RICHARD WRIGHT FOR MONTHLY TREATMENT REVIEW AND INDIVIDUAL COUNSELING	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
WRIGHT, RICHARD	187140		B/M	BULLOCK COUNTY

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
6/13/02	2:30 pm	S: "I'm not mentally ill. I'm not taking any more medicine." O: Remains in safe cell re: mental health observation. Calm. Cooperative. No devious affective or thought impairment. Denies wanting to harm self and/or others. Long history of non-compliance with medication. Alert & oriented to person, place, time, & situation. Remains suspicious re: "why everybody wants him to take medicine he doesn't need" — A: Stable mood. P: D/C safe cell. Release to RTU. Appropriate DOC staff advised. — — Audrey Dorman, CRNP —	
Addendum		— MH education per MH nurse. — Encourage meds. Individual counseling per tx. coordinator. — Audrey Dorman, CRNP —	
6/14/2002	9:17	TREATMENT Coordinator Note: Contact with Richard Wright to initiate treatment plan and individual counseling session. Mr. Wright reported a conflict with an inmate that led him to the Infirmary (Safe cell) for Medical Observation. The client was referred to group therapy but refused due to isolation or noninvolvement in group	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Wright, Richard	187140	34	B/M	BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
6/7/02	9:20 am	S/O: Officers report inmate constantly cleaning floor. Inmate seen in seg. cell – floor wet. Inmate has been cleaning floor & wet towels from toilet. Inmate says he must clean "all the time" & that he can't get cell clean. Affect - smiling widely. Says radio talks specifically to him. Denies hearing voices. Denies paranoia. Refusing to take Prolixin Injections as ordered. Is compliant with PO Haldol 2 mg/day + Artane 2 mg + Lithium 600 mg q hs. No labs available for review. A: R/O hypomania. P: ① ↑ Lithium to 900 mg q hs. 2. Labs: Thyroid profile & TSH; Multichem profile, UA, CBC Lithium level next week. ③ Cont. MH observation. — Audrey Dorman, CRNP	
6/10/02	1000	Seen in seg. Inmate oriented x 3 Continues to deny hallucinations. Blood drawn for requested labs. Inmate cooperative Continues to c/o "cell being too dirty." Unable to get specimen for UA @ this time. — G.M. Counts, M	
6/12/02	3:55 pm	S: Inmate continues to refuse ordered Prol. inj. O: alert. Suspicious re: ordered meds & verbalizes harm from meds. despite no evidence A: Impaired thinking P: Increase Haldol to 4 mg. Advise inmate. – Audrey Dorman, CRNP	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Wright, Richard	187140	34	B/M	BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
6/5/02	845am	Seen in Seg. Has ear-phones on during conversation/interaction. Says radio is off & he's "just wearing" ear-phones. Affect broad. Pleasant. Cooperative. Officers report ↓ behavior management problems while in Seg. Currently compliant c meds. Will cont. M.H. observation - eval. for release in a.m. ——— Audrey Dorman, CRNP ———	
6/6/02	1130am	S/O: alert. Somewhat disoriented. Unable to communicate in a meaningful fashion. Loose associations. Smiling inappropriately affect. Calm. Cooperative. A: alteration in thought process. ↓ AIMS. P: Prolixin Dec 25mg IM q 2 weeks - renewed. Artane 2 mg PO BID discontinued. will give 2 mg/dly. Eval. in a.m. + prn. Cont. MH. observation. ——— Audrey Dorman, CRNP ———	
6/6/02	1330	Inmate refused prolixin dec 25mg injection, stating "I ain't taking no shot. Remains in seg cell. DOC officers report inmate eating well for all meals.	T.H. Counts, RN

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Wright, Richard	187140	34	B/M	BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
3/4/2002	2:46	TREATMENT COORDINATOR NOTE: CONTACT WITH RICHARD WRIGHT TO REVIEW TREATMENT PLAN. MR. WRIGHT HAS DIFFICULTY CONTROLLING HIS VIOLENT BEHAVIOR, HAS AN ALCOHOL AND DRUG HISTORY, AND INCOMPLETION OF REQUIREMENTS FOR HIGH SCHOOL DIPLOMA. THE CLIENT WILL BE REFERRED TO ANGER MANAGEMENT GROUP, GED PROGRAM, AND SUBSTANCE ABUSE PROGRAM. MR. WRIGHT NEXT TREATMENT REVIEW WILL BE CONDUCTED BY APRIL 4, 2002. T. WILLIS, M.S.	
3/11/2002	1:09	TREATMENT COORDINATOR NOTE: CONTACT WITH RICHARD WRIGHT FOR MONTHLY TREATMENT REVIEW AND INDIVIDUAL SESSION. MR. WRIGHT HAS BEEN REFERRED TO AND SCHEDULED TO BEGIN CURRENT EVENTS I/II DUE TO COMPLETION OF OTHER GROUPS AND LEVEL 4 STATUS. MR. WRIGHT NEXT MONTHLY REVIEW WILL BE CONDUCTED BY APRIL 4, 2002. T. WILLIS, M.S.	
3/25/2002	11:21	TREATMENT CORDINATOR NOTE: BI-WEEKLY REVIEW UPDATE ON RICHARD WRIGHT. MR. WRIGHT HAS BEEN MOVED TO POPULATION, LIVING IN DORM 19 BED 17. T. WILLIS, M.S.	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
WRIGHT, RICHARD	187140		B/M	BULLOCK COUNTY

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INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
2/25/02	S.	Pt seen on SU. Pt continues to insist that he does not need medication. Otherwise, pt says he is doing well.	
	O.	Pt is A+O×4. He is neatly and appropriately groomed. Pt is cheerful, talkative, polite, and well-behaved. No overt distress noted.	
	A.	Pt is currently stable but will likely deteriorate if not on meds soon. Currently his thought process are logical & coherent with no psychotic intrusion evident.	
	P.	Continue to monitor.	A. Mitchell, M.S.

Patient';s Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Wright, Richard	187140		B/M	KCF

Group Name: Recovery Concepts **Date/Time:** 4/25/02 10:00 AM

Dress/Grooming:	Appropriate	Marginal	Disheveled		
Motor Activity:	Decreased	Agitation	Tremors		
General Attitude/Behavior:	Spontaneous	Preoccupied	Suspicious	Argumentative	Withdrawn
	Participated	Passively Attentive	Inattentive	Disruptive	Hostile
Mood/Affect:	Flat	Depressed	Euphoric	Anxious	Unremarkable
Speech:	Normal	Slurred	Rapid	Talkative	Mute
Flight of Ideas:	N/A Confabulation	Tangential	Loose Associations		
Thought Content:	Suicidal Thought/Plans	Homicidal Thought/Plans	Bizarre	Obsessive	Suspicious
	Inadequacy	Poverty of Content	No deficit identified	Helplessness	
Delusions:	? More Hypomanic None	Persecution	Systematized	Somatic	
Hallucinations:	None	Auditory	Visual		
Insight/Judgment:	Unimpaired	Poor Judgment	Poor Insight		

Admit no need for meds.

Group Leaders Name & Signature: Rebecca T. Harrison

Name: Wright AIS: 187261

Group Name: Relationships **Date/Time:** 1:02 PM

Dress/Grooming:	Appropriate	Marginal	Disheveled		
Motor Activity:	Decreased	Agitation	Tremors		
General Attitude/Behavior:	Spontaneous	Preoccupied	Suspicious	Argumentative	Withdrawn
	Participated	Passively Attentive	Inattentive	Disruptive	Hostile
Mood/Affect:	Flat	Depressed	Euphoric	Anxious	Unremarkable
Speech:	Normal	Slurred	Rapid	Talkative	Mute
Flight of Ideas:	N/A Confabulation	Tangential	Loose Associations		
Thought Content:	Suicidal Thought/Plans	Homicidal Thought/Plans	Bizarre	Obsessive	Suspicious
	Inadequacy	Poverty of Content	No deficit identified	Helplessness	
Delusions:	More Hypomanic None	Persecution	Systematized	Somatic	
Hallucinations:	None	Auditory	Visual		
Insight/Judgment:	Unimpaired	Poor Judgment	Poor Insight		

Appropriate -

Group Leaders Name & Signature:

Name: Wright Richard AIS: 187261

Group Name: Job and Mental Health Pt 1 **Date/Time:** 2-15-02 10:00AM

Dress/Grooming:	Appropriate	Marginal	Disheveled		
Motor Activity:	Decreased	Agitation	Tremors	APPROPRIATE	
General Attitude/Behavior:	Spontaneous	Preoccupied	Suspicious	Argumentative	Withdrawn
	Participated	Passively Attentive	Inattentive	Disruptive	Hostile
Mood/Affect:	Flat	Depressed	Euphoric	Anxious	Unremarkable
Speech:	Normal	Slurred	Rapid	Talkative	Mute
Flight of Ideas: NONE	Confabulation	Tangential	Loose Associations		
Thought Content: NONE	Suicidal Thought/Plans	Homicidal Thought/Plans	Bizarre	Obsessive	Suspicious
	Inadequacy	Poverty of Content	No deficit identified	Helplessness	
Delusions:	None	Persecution	Systematized	Somatic	
Hallucinations:	None	Auditory	Visual		
Insight/Judgment:	Unimpaired	Poor Judgment	Poor Insight		

Group Leaders Name & Signature: B. Wright M.HP.

Name: Wright, Richard AIS: 187140

Group Name: Job and Mental Health Part II **Date/Time:** 2-15-02 1:00pm

Dress/Grooming:	Appropriate	Marginal	Disheveled		
Motor Activity:	Decreased	Agitation	Tremors	APPROPRIATE	
General Attitude/Behavior:	Spontaneous	Preoccupied	Suspicious	Argumentative	Withdrawn
	Participated	Passively Attentive	Inattentive	Disruptive	Hostile
Mood/Affect:	Flat	Depressed	Euphoric	Anxious	Unremarkable
Speech:	Normal	Slurred	Rapid	Talkative	Mute
Flight of Ideas: NONE	Confabulation	Tangential	Loose Associations		
Thought Content: NONE	Suicidal Thought/Plans	Homicidal Thought/Plans	Bizarre	Obsessive	Suspicious
	Inadequacy	Poverty of Content	No deficit identified	Helplessness	
Delusions:	None	Persecution	Systematized	Somatic	
Hallucinations:	None	Auditory	Visual		
Insight/Judgment:	Unimpaired	Poor Judgment	Poor Insight		

Group Leaders Name & Signature: B. Wright M.HP.

Name: Wright, Richard AIS: 187140